

Virginia Department of Health  
Division of Tuberculosis Control  
Newcomer Health Program  
Annual Report 2003

**Background:**

Each year thousands of persons leave their homelands to settle in new and distant lands. Among these are refugees who are defined as persons forced to flee his/her country of origin because of a well-founded fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group. Many refugees spend months or years in hastily set up refugee camps, awaiting the right to return home or to resettle in a new country kind enough to provide long-term refuge. The United States (U.S.) has a long history of accepting refugees from around the world. During the years following World War II, refugees have been designated a distinct class of legal immigrants, who based on social or political criteria, are designated as in need of humanitarian protection and safe haven.

The term refugee is used throughout this document and refers to the following eligible immigrant groups:

- *Refugees* are defined in the previous paragraph.
- *Asylees* are defined as foreign nationals that cannot return to their country of origin or residence because of a well-founded fear of persecution because of race, nationality, and membership in a particular social group. *Asylees* apply for and receive this status *after* entering the United States, while refugees apply for and receive their status *before* entering the United States.
- *Cuban and Haitian Entrants* are defined as persons of Cuban or Haitian origin granted parole status or special status under United States immigration laws.
- *Amerasians* are defined as persons of Asian and American descent, primarily children fathered by American servicemen and born between 1/1/1962 and 1/1/1976.

- *Unaccompanied Minors* are defined as refugee children (under 18 years of age) that arrive in the United States unaccompanied by a parent or other close adult relative and will required foster care.
- *Victims of Trafficking* are persons who have been victim of sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or persons that have been recruited, harbored, transported etc for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. This group was included in the refugee group as of 2000.

Each of these groups will have a different legal status as listed on their I-94 card an Immigration and Naturalization Service (INS) document. *Victims of Trafficking* are provided a letter of certification instead of an I-94. All are eligible for benefits administered by the Office of Refugee Resettlement (ORR) in the US Department of Health and Human Services. In the U.S., many refugees are assisted in their resettlement process by humanitarian or faith-based voluntary agencies (VOLAGs). Funding available through ORR assists these agencies with the resettlement process.

Under the Federal Refugee Act of 1980, a uniform system of services was created for refugees resettling in the United States. The purpose of this act was “to provide for the effective resettlement of refugees” and “to assist them to achieve economic self-sufficiency as quickly as possible”. Among the benefits provided to refugees under this Act is a comprehensive health assessment, which should be performed as soon after arrival as possible and which is designed to identify and eliminate health related barriers to successful resettlement while protecting the health of the U.S. population. Federal Refugee Medical Assistance (RMA) funds are provided to each state to underwrite the cost of these medical assessments.

The Office of Newcomer Services, which administers the federal RMA funds in Virginia, works through the Virginia Department of Health (VDH), Division of Tuberculosis Control (DTC), Newcomer Health Program (NHP) to coordinate, facilitate, and monitor the provision of initial

health assessment services to newly arrived refugees. Through a preventive health grant ORR provides funding to the NHP to maintain necessary infrastructure. Because tuberculosis (TB) infection and disease are common health problems observed in the refugee population, the Virginia NHP became a part of the Division of TB Control (DTC) in 1997.

### **Overseas Medical Assessment:**

All immigrants (any person entering the U.S. as a lawful permanent resident (LPR)) are required by law to undergo medical examination *overseas*, *prior* to their resettlement in the US. Refugees also must receive this medical examination prior to US entry. The examination is designed to identify certain medical conditions that may deny the person entry into the US. Presently, these *excludable conditions* are defined as:

- A communicable disease of public health significance (*e.g.* potentially infectious tuberculosis, certain sexually transmitted diseases, HIV infection/AIDS, Hansen's disease)
- A current or past physical or mental disorder that is associated with harmful behavior
- Drug abuse or addiction.

Identification of an excludable condition during the overseas examination results in assignment of a "classification". Persons designated with a "Class A" condition cannot enter the U.S. Although the presence of any of these diseases, termed as *excludable conditions*, prevents the granting of an entry visa, a waiver process exists for non-refugee immigrants, with some "Class A" conditions. If an applicant with HIV infection, for example, can demonstrate the means to financially support his or her health care in the US, a waiver for entry may be issued. Refugees, with HIV infection, are admitted on a case-by-case basis, also with a waiver while the financial support for their health care may be covered under RMA funds or other public funds. There is no waiver provision for visa applicants with drug abuse or addiction.

The system for classifying individuals with tuberculosis is more complex. Those with potentially infectious tuberculosis (defined by the presence of positive smears) are designated "Class A"

tuberculosis. These persons are required to begin treatment overseas and when non-infectious they may reapply for an entry visa, with a waiver. Persons with evidence of active tuberculosis on chest radiograph but negative sputum smears are designated as “Class B1” tuberculosis, while those who have radiographic evidence of inactive tuberculosis are “Class B2” tuberculosis.

In 1996, the US Congress amended the Immigration and Nationality Act (INA) and revised the health related grounds of inadmissibility. A subsection, *Proof of Vaccination Requirements for Immigrants*, was added, which requires any alien who seeks an immigrant visa or an adjustment to status as a LPR to present proof of vaccination against certain vaccine preventable diseases. Refugees must comply with this requirement by the time they apply for adjustment of status, one year after arrival into the US.

#### **Admission into the U.S.:**

In the United States, quarantine stations are located at eight major international airports. Each station has responsibility for all ports of entry in an assigned geographic area. All arriving passengers and crew are observed for signs and symptoms of illness. Passengers meeting certain criteria may be questioned or detained. Arriving aliens (immigrants and refugees) particularly those with Class A or B classifications will have their medical documents and immunization records reviewed for completeness. Refugees normally arrive at ports where quarantine inspectors are assigned, but this may not always be the case. If a quarantine inspector is not available, an immigration inspector will review the refugees’ documents and report the information to the station that covers that geographic area. Immigrants and refugees with classified health conditions are reminded, at the port of entry, that they need to report to the local health department where they intend to resettle, for an evaluation of that classified health condition. Refugees are reminded to report to the local health department for an initial health assessment. The quarantine stations will then send a “Notification of Arrival” and the alien’s medical documentation to the state health department in which the immigrant or refugee has indicated they will resettle.

**Arrival to Virginia:**

In Virginia the NHP receives these Notifications of Arrival and medical information, for all refugees and any immigrant with a classified health condition entering the state. Since 1997, the NHP has entered demographic information from these notifications into a program database, prior to their distribution to the local health district. This refugee database has allowed for tracking of refugee arrivals to the various health districts within Virginia. The database also collects basic health information so that emerging health trends in this population may be identified.

**The Domestic Refugee Medical Assessment:**

For many years, local health districts in Virginia have provided some level of health assessment services to newly arriving refugees. These services had been paid for by the refugee or out of local health district budgets. With incorporation of the NHP into DTC, a statewide protocol for the Refugee Health Assessment that included a standardized health assessment was implemented. The program database also facilitates the reimbursement schedule for the assessment from DSS to the local health districts. The NHP allowed for three Levels to the health assessment, ranging from a complete health assessment to the minimum, an evaluation for tuberculosis. The Program further designed the RMA reimbursement to reflect the level of service provided by districts.

- **Level I** is the evaluation for tuberculosis disease or infection includes an assessment for clinical signs and symptoms, placement and reading of a tuberculin skin test, and a chest x-ray and therapy as indicated.
- **Level II** includes a more complete patient inspection or assessment, some laboratory testing as indicted, and an assessment of immunization status.
- **Level III** includes listening for abnormalities of heart and lung sounds and any further testing appropriate for age, such as developmental testing for young children, further evaluation for anemia findings, cardiovascular disease, cancer, and /or sexually transmitted diseases as indicated.

- **Level IV** is case management. Many refugees require some level of case management by a public health nurse and so Level IV was designed to not only to capture these data but also to reimburse health districts for the knowledge and skill required to perform this case management.

\*\*Attached is an Excel spreadsheet that notates, for the years 1997 through 2003, the health district, number of refugee assessments returned and invoiced for RMA reimbursement and the amount of the RMA reimbursement.

### **Program Data:**

For the period from January 2003 through December 2003, 1220 persons with refugee status have entered the Commonwealth. Of these, (159) claim Sierra Leone as their country of origin. Other common countries of origin include, Ethiopia (148), Iran (141), Cuba (123), Somalia (102), and Afghanistan (101). The remaining 446 (36.5%) hail from another 45 different countries.

**Table 1: Refugee arrivals by world region for this period are as follows:**

<b>World Region</b>	<b>Number Arrivals</b>	<b>Percent</b>
Africa	466	38.2
Americas	139	11.4
Asia	9	0.7
Europe	121	9.9
Eastern Mediterranean	456	37.4
Western Pacific	29	2.4
<b>All Regions</b>	<b>1220</b>	<b>100%</b>

Of these new refugees, program data indicate the majority (56%) resettled in Northern Virginia, predominately in the counties of Fairfax and Arlington and the city of Alexandria. This is followed by the northwest region (14%), primarily the Charlottesville and Harrisonburg areas. Central Virginia, mainly Henrico County, became home to 11% of new refugees. The eastern region, Hampton Roads received 10% of new refugee arrivals for this period. And lastly, the southwest region or Roanoke area became home to 113 (9%) refugees.

**Table 2: Refugee arrivals by health region:**  
(n=1220)

<b>Health Region</b>	<b>Number Refugees</b>	<b>Percent</b>
Central	127	11
Eastern	123	10
Northern	686	56
Northwest	171	14
Southwest	113	9

Of refugees received in Virginia for this same period, 141 or (12%) entered with a classified health condition.

**Table 3: Breakdown of Classified Health Conditions:**

<b>Health Condition</b>	<b>Percent</b>
Tuberculosis Class A	0.08%
Tuberculosis Class B1	0.6%
Tuberculosis Class B2	0.9%
HIV Infection	0.6%
“Other”	12%

“Other” accounts for a number of health conditions such as hypertension, diabetes, cancer, developmental delays, traumatic wounds, amputations, scarring, etc. Class B other does not affect immigration into the US.

Program data show that 956 (78%) of the total refugees received, a minimum, Level I of the initial health assessment. These assessments were provided anywhere from 10 days to 93 days or an average of 42days, from the time of arrival into the US. That refugees receive a health assessment within 30 days of arrival into the US is an objective that the Department of State and ORR has set for VOLAGs resettling refugees. Program data also indicate that 80 (7%) of refugees did not receive health assessment services from local health districts. Many resettled another state soon after arrival into the US, declined a health assessment, some received their health assessment from a private provider, and, while some could not be located. The NHP has no return information for the remaining 15% so it is unknown whether they received a health assessment.

**Table 4: Refugee Health Assessments Completed by Health Region and District:**

<b>Northern</b>	<b>#</b>	<b>Northwest</b>	<b>#</b>	<b>Southwest</b>	<b>#</b>	<b>Central</b>	<b>#</b>	<b>Eastern</b>	<b>#</b>
Alexandria	70	Central Shenandoah	59	Roanoke	107	Chesterfield	9	Peninsula	62
Arlington	140	Rappahannock	2			Hanover	7	Va. Beach	9
Fairfax	262	Thomas Jefferson	87			Henrico	84	Western Tidewater	6
Loudoun	13								
Prince Wm.	39								
<b>Totals</b>	<b>524</b>		<b>148</b>		<b>107</b>		<b>100</b>		<b>77</b>

All 956 refugees assessed received a Level I assessment, the evaluation for tuberculosis. Of these, 18 (2%) were diagnosed with either suspected or confirmed tuberculosis disease and 492 (51%) refugees were diagnosed with latent tuberculosis infection.

Of the 956 refugees that received a health assessment, 854 (89%) received Level II assessments. Level II of the assessment, not only includes a review of necessary immunizations, but also identifies other health problems of this population on their arrival to the U.S.

**Table 5: The prevalence of these selected health problems is reported as follows: (n=854)**

<b>Health Problem</b>	<b>Number Refugees</b>	<b>Percent</b>
Dental Needs	259	30%
Vision or Hearing Problems	136	16%
Low Weight	43	5%
Anemia	90	11%
Pregnancy	9	1.1%
Mental Delay or Abnormality	2	0.2%

**Table 6: Immunizations needed or provided at the initial health assessment are reported as follows: (n=854)**

<b>Immunization</b>	<b>Number</b>	<b>Percent</b>
Diphtheria, Tetanus and or Pertussis	781	91
Polio (IPV)	311	36
Measles, Mumps, and Rubella	688	81

H. influenzae type b (HIB)	--	--
Hepatitis B Vaccine	386	45
Varicella	400	47
Pneumococcal Vaccine	54	6
Influenza	68	8

That refugees receive their required immunizations soon after arrival into the US is another goal VOLAGs strive to meet. Refugees must be vaccinated against all vaccine preventable diseases when they apply for change of status to LPR, once in the US one year.

**Table 7: For refugees receiving a Level II assessment, follow up referrals for a health need identified are reported as follows:**  
(n=854)

Identified Health Need	Number	Percent
Abnormal or normal dental	573	67
Follow up immunizations	805	94
Abnormal vision and hearing	156	18
Intestinal or blood parasites	121	14
Hepatitis B or C finding	76	9
Development Delay (children)	<2	<1
Mental health	18	<3
Other	336	39

Other includes health conditions such as pregnancy, hypertension, diabetes, cancer, and mental health, traumatic wound care or revisions, and so on. These data do not fully represent health needs of the total refugee population. Two VDH health districts do not provide Level II and III of the health assessment.

#### **Achievements for the Period:**

The NHP program held a two-day nurse training for local district staff in October 2003. This training was well attended by front line personnel. ONS and Virginia VOLAGs provided presentations describing the refugee resettlement process in U.S. and in Virginia. The VDH state epidemiologist presented an excellent review of disease conditions usually seen in refugee and immigrant populations.

Virginia remains one of eight states ready to pilot an electronic notification of immigrant arrival project headed by the Centers for Disease Control and Prevention, Divisions of Global Migration and Quarantine (DGMQ) and Tuberculosis and Elimination (DTBE). An expectation of this electronic notification is that states will receive more timely health information for classified aliens and refugees entering their respective state or big city.

The NHP continues to work aggressively to increase the visibility of the RHP with the Virginia Department of Health (VDH). In January 2003, a new director came to the VDH DTC program. Margaret Tipple, M.D. is very interested in Virginia's refugee health program and is actively promoting the program to all the local health directors. Formerly with the CDC, Global Migration and Quarantine, Dr. Tipple brings a wealth of experience to the program.

In September of 2002 the RHP hired a permanent wage support person. Ms. Coggsdale has proven she is able to manage the daily aspects of the program with very little assistance from the coordinator.

NHP launched its WEB page the week of World Refugee Day 2003. We are also now in the process of updating the web information available. We continue to develop a page entitled "Ethnicity of the Month" for this site. This topic has been well received and the Centers for Disease Control, Tuberculosis Elimination has asked that we share an article on this topic for their quarter news.

Within VDH, NHP has contributed information on refugees to news alerts sent out by the Health Commissioner. The topics included were health care disparities for special populations and health care for the uninsured week, as well as for World Refugee Day.

Together with ONS a request was made to the Governor's office that the Commonwealth prepare a proclamation for World Refugee Day. Copies of the proclamation were provided to Virginia VOLAG directors.

The NHP coordinator continues to attend monthly Policy Committee meetings with the ONS Director, Kathy Cooper. Those agencies with which ONS has contract agreements are encouraged to attend these meetings. The committee offers advice and counsel to the ONS director regarding resettlement issues and programmatic issues. Many policy items are discussed as well as directors have an opportunity to network with one another

The NHP coordinator has assisted in facilitating more timely and improved quality of the health assessment in several health districts. Providing an assessment to refugees is something new for some staff. The local VOLAGs have been networking with various local health departments. In most districts public health services for refugees are being rendered more readily. In one area, a university hospital has developed a clinic for immigrants. This clinic works closely with the local health department to provide follow up care to refugees in the area.

Local health districts are struggling to meet the language needs of Virginia's new refugees. The program has contracted with several service providers to help the districts meet this need. The coordinator has placed funds with the Northern Virginia Area Health Education Network and with various VOLAGs operating in Virginia. These funds can be used for these agencies to provide interpreter services during the initial health assessments performed by VDH local health departments. Many times the caseworker provided by the VOLAG speaks the refugees' language. The NHP continues to collect information on the refugee primary language as well as district medical interpretation needs. The program anticipates it may contain enough data to analyze and help with appropriate distribution of funds from this project to local health districts. This allows for an improved health assessment and needed medical follow up.

The health coordinator now also participates the partnership meetings held by ONS and its partners in resettlement. In this venue, the coordinator is able to highlight the health coordination of the resettlement process in Virginia.

**Conclusion:**

In recent years the arriving refugee population has become more diverse. Considering the many countries of origin, the resources needed to provide services in many languages and dialects is overwhelming for providers. VDH health districts also struggle to meet the requirements of Title VI of the Civil Rights Act of 1964. Providing culturally and linguistically appropriate services to their clients is a continuing challenge as the US population becomes increasingly diverse. VOLAGs and Virginia's Area Health Education Centers can be of assistance to local health districts, and other health providers, in meeting this need of Virginia's new refugees. NHP has placed funds with several Northern Virginia AHEC and VOLAGs in Virginia to pay for interpreter services at the VDH initial health assessment. A web site [www.refugee.org/world](http://www.refugee.org/world) may also assist providers in understanding our refugees' cultural and needs.

The public health system is uniquely qualified to identify conditions of public health significance. Refugees, as all newcomers to the US, must learn to navigate the US health care system, which can be overwhelming to many. A holistic approach to provide health care to this vulnerable population is imperative for the first months in their new country. That health districts provide a detailed assessment of each refugee newcomer is essential to this process. Health districts are encouraged to begin the orientation process to our health care system, while providing referrals to follow up of health programs identified at the assessment. Providing appropriate treatment for TB disease and latent TB infection is but one example of treating the condition, while providing education to the client and protecting the public health.

Immunization of refugees against all vaccine preventable diseases is not only a good public health practice, but also now the law. Refugees are required show proof of immunizations to change their legal residency status, which they are required to do one year after arrival into the US. Health districts are encouraged to begin providing immunizations as refugees present to them, stressing the need for follow up and maintaining their records. Exploring new partnerships with local private providers for follow up of identified health needs is critical, as health districts no longer provide primary care. Other than tuberculosis conditions, dental health is identified as

the most common problem for refugees. Identifying local resources to provide dental care for this group is crucial to oral and over all health.

Mental health has been an identified problem for many refugees. As survival is a coping mechanism for the refugee, the need for mental health care may not manifest until the refugee has been in the US for a period of time. Districts are encouraged to network with local Community Service Boards in providing some of the needed mental care to newcomers. Health professionals are encouraged to be available for counseling and treatment as these needs arise in the refugee. ORR has funded several projects, nationally, to provide services for victims of torture. A Program for Survivors of Torture and Severe Trauma (PSTT) is located in Falls Church, Virginia. Contact the Center for Multi Cultural Human Services at 703-533-3302.

Effective August of 2001, the VDH RHP has had a full time dedicated coordinator. We know this vulnerable population presents a challenge to our local health districts and other providers. Program data do assist in an overall assessment of the program and can help plan for more effective use of program resources. A concern is that all refugees may not be receiving an assessment of their immunization status.

In October of 2003, The Refugee and Immigrant Health Program along with the Division of Tuberculosis Control health a Public Health Nurse Training Conference. All health districts were represented. Presentations on health conditions seen in the refugee population, cultural awareness for the health provider, mental health issues, as well as, migration issues were provided. Four districts shared information about their Refugee Health Programs. Plans are underway for another Public Health Nurse training to be held in December 2004.

Refugee admissions, like all immigration into the U.S. slowed after the events of September 11, 2001. Each year in October the president, based on recommendations from the Secretary of State and Congress, declares the number of refugees the U.S. will accept that year. The Bush administration had declared that the U.S. would accept 70,000 refugees in FY02, 03 and 04;

however we did not met this number. For FY 2004, it is probable that 50,000 will be admitted. However in an ever-changing world, refugee admissions can change at any time.

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Attachment: 1